IDAPA 17 - INDUSTRIAL COMMISSION

17.02.08 - MISCELLANEOUS PROVISIONS

DOCKET NO. 17-0208-0802

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 72-508, 72-720, 72-721, 72-722, AND 72-723, Idaho Code, and Section 72-803 of the Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

WEDNESDAY OCTOBER 15, 2008 3:00 pm - 5:30 pm	TUESDAY OCTOBER 28, 2008 3:00 pm - 5:30 pm	WEDNESDAY OCTOBER 29, 2008 3:00 pm - 5:30 pm
Best Western Coeur d'Alene Inn 506 W. Appleway Ave. Coeur d'Alene, ID	Industrial Commission 700 S. Clearwater Lane Boise, ID	Holiday Inn Express 2270 Channing Way Idaho Falls, ID

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

1. Mandated by Section 72-803, Idaho Code, requiring an adjustment each fiscal year by the amount determined by the Director of Health and Welfare in accordance with the procedure set out in Section 56-136, Idaho Code. Adjusts the conversion factors paid to medical providers by the inflation factor percentage determined by the Director of Health and Welfare for Medicaid covered services.

2. To clarify that these rules are applicable to all entities providing services to injured workers even as agents. Changes the definition of a medical "provider" to include any person or entity acting on behalf of a provider with respect to medical charges payable under this rule.

3. To provide a medical fee schedule for hospitals providing medical services to injured Idaho workers similar to that established for physicians.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: There is no fiscal impact with the proposed changes.

NEGOTIATED RULEMAKING: In compliance with Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because it was determined that broader input would be obtained through formal rulemaking and public hearings or the changes were mandated by statute.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Patti Jarossy at (208)334-6084.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 31, 2008.

DATED this 19th day of August, 2008.

Mindy Montgomery, Director
Idaho Industrial Commission
700 S. Clearwater Lane, P.O. Box 83720
Boise, ID 83720-0041
Phone: 208-334-6000; Fax: 208-334-5145

THE FOLLOWING IS THE TEXT OF DOCKET NO. 17-0208-0802

031. ACCEPTABLE CHARGES FOR MEDICAL SERVICES UNDER THE IDAHO WORKERS' COMPENSATION LAW.

Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Industrial Commission (hereinafter "the Commission") hereby adopts the following rule for determining acceptable charges for medical services provided under the Idaho Workers' Compensation Law: (3-12-07)

01. Definitions. Words and terms used in this rule are defined in the subsections which follow. (6-1-92)

a. ~~"~~Acceptable Charge~~".~~ ~~*means t*~~The lower of the charge for medical services calculated in accordance with this rule or as billed by the provider, or the charge agreed to pursuant to written contract. ~~*(3-12-07)*~~( )

b. Ambulatory Payment Classification (APC). A payment system adopted by Medicare for outpatient services. ( )

~~*b*~~**c.** ~~"~~Ambulatory Surgery Center (ASC)~~".~~ ~~*means a*~~ A facility providing surgical services on an outpatient basis only. ~~*(4-2-08)*~~( )

d. Critical Access Hospital. A hospital which meets all of the current designation criteria of the Centers for Medicare and Medicaid Services (CMS) for a critical access hospital, including, but not limited to, the maximum number of beds and minimum distance from other hospitals. ( )

~~*c*~~**e.** ~~"~~Hospital~~".~~ ~~*is a*~~Any acute care facility providing medical or hospital services and which bills using a Medicare universal hospital billing form. ~~*(4-2-08)*~~( )

~~*i. Large hospital is any hospital with more than one hundred (100) acute care beds. (4-2-08)*~~

~~*ii. Small Hospital is any hospital with one hundred (100) acute care beds or less. (4-2-08)*~~

f. Implantable Hardware. Objects or devices that are made to support, replace or act as a missing anatomical structure and where surgical or medical procedures are needed to insert or apply such devices and surgical or medical procedures are required to remove such devices. The term also includes equipment necessary for the proper operation of the implantable hardware, even if not implanted in the body. ( )

g. Medicare Severity -- Diagnosis Related Group (MS-DRG). A system adopted by the Centers for Medicare and Medicaid Services (CMS) that groups hospital admissions based on diagnosis codes, surgical procedures and patient demographics. ( )

~~*d*~~**h.** ~~"~~Provider~~".~~ ~~*means a*~~Any person, firm, corporation, partnership, association, agency, institution or other legal entity providing any kind of medical service related to the treatment of an industrially injured patient which ~~*are*~~ is compensable under Idaho's Workers' Compensation Law. This includes any person or entity acting for, on behalf of, or in place of a provider, or one that has acquired or succeeded to the interests of a provider with respect

to charges payable under this rule. *(3-12-07)*( )

***e*i.** ~~"~~Payor~~".~~ *means t*The legal entity responsible for paying medical benefits under Idaho's Workers' Compensation Law. *(6-1-92)*( )

***f*j.** ~~"~~Medical Service~~".~~ *means m*Medical, surgical, dental or other attendance or treatment, nurse and hospital service, medicine, apparatus, appliance, prostheses, and related service, facility, equipment and supply. *(3-12-07)*( )

***g*k.** ~~"~~Reasonable~~,".~~ *means a*A charge that does not exceed the Provider's "usual" charge and does not exceed the "customary" charge, as defined below. *(3-12-07)*( )

***h*l.** ~~"~~Usual~~".~~ *means t*The most frequent charge made by an individual Provider for a given medical service to non-industrially injured patients. *(3-12-07)*( )

***i*m.** ~~"~~Customary~~".~~ *means a*A charge which shall have an upper limit no higher than the 90th percentile, as determined by the Commission, of usual charges made by Idaho Providers for a given medical service. *(3-12-07)*( )

02. Acceptable Charge. Payors shall pay providers the acceptable charge for medical services. (3-12-07)

a. Adoption of Standard for Physician Services. The Commission hereby adopts the Resource-Based Relative Value Scale (RBRVS), published by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, as amended, as the standard to be used for determining the acceptable charge for medical services provided under the Idaho Workers' Compensation Law by providers other than hospitals and ASCs. *The standard for determining the acceptable charge for hospitals and ASCs shall be:* *(4-2-08)*( )

i. For large hospitals: Eighty five percent (85%) of the appropriate inpatient charge. *(4-2-08)*

ii. For small hospitals: Ninety percent (90%) of the appropriate inpatient charge. *(4-2-08)*

iii. For ambulatory surgery centers (ASCs) and hospital outpatient charges: Eighty percent (80%) of the appropriate charge. *(4-2-08)*

iv. Surgically implanted hardware shall be reimbursed at the rate of actual cost plus fifty percent (50%). *(4-2-08)*

v. Paragraph 031.02.e., shall not apply to hospitals or ASCs. The Commission shall determine the appropriate charge for hospital and ASC services that are disputed based on all relevant evidence in accordance with the procedures set out in Subsection 032.10. *(4-2-08)*

b. Conversion Factors. The following conversion factors shall be applied to the fully-implemented facility or non-facility Relative Value Unit (RVU) as determined by place of service found in the latest RBRVS, as amended, that was published before December 31 of the previous calendar year for a medical service identified by a code assigned to that service in the latest edition of the Physicians' Current Procedural Terminology (CPT), published by the American Medical Association, as amended:

MEDICAL FEE SCHEDULE			
SERVICE CATEGORY	**CODE RANGE(S)**	**DESCRIPTION**	**CONVERSION FACTOR**
Anesthesia	00000 - 09999	Anesthesia	*$58.19* $ 60.05

MEDICAL FEE SCHEDULE			
SERVICE CATEGORY	**CODE RANGE(S)**	**DESCRIPTION**	**CONVERSION FACTOR**
Surgery - Group One	22000 - 22999 23000 - 24999 25000 - 27299 27300 - 27999 29800 - 29999 61000 - 61999 62000 - 62259 63000 - 63999	Spine Shoulder, Upper Arm, & Elbow Forearm, Wrist, Hand, Pelvis & Hip Leg, Knee, & Ankle Endoscopy & Arthroscopy Skull, Meninges & Brain Repair, Neuroendoscopy & Shunts Spine & Spinal Cord	~~$140~~ $144.48
Surgery - Group Two	28000 - 28999 64550 - 64999	Foot & Toes Nerves & Nervous System	~~$125~~ $129.00
Surgery - Group Three	13000 - 19999 20650 - 21999	Integumentary System Musculoskeletal System	~~$110~~ $113.52
Surgery - Group Four	20000 - 20615 30000 - 39999 40000 - 49999 50000 - 59999 60000 - 60999 62260 - 62999 64000 - 64549 65000 - 69999	Musculoskeletal System Respiratory & Cardiovascular Digestive System Urinary System Endocrine System Spine & Spinal Cord Nerves & Nervous System Eye & Ear	~~$85~~ $87.72
Surgery - Group Five	10000 - 12999 29000 - 29799	Integumentary System Casts & Strapping	~~$67~~ $69.14
Radiology	70000 - 79999	Radiology	~~$85~~ $87.72
Pathology & Laboratory	80000 - 89999	Pathology & Laboratory	To Be Determined
Medicine - Group One	90000 - 90799 94000 - 94999 97000 - 97799 97800 - 98999	Immunization, Injections, & Infusions Pulmonary / Pulse Oximetry Physical Medicine & Rehabilitation Acupuncture, Osteopathy, & Chiropractic	~~$45~~ $46.44
Medicine - Group Two	90800 - 92999 96040 - 96999 99000 - 99607	Psychiatry & Medicine Assessments & Special Procedures E / M & Miscellaneous Services	~~$64.50~~ $66.56
Medicine - Group Three	93000 - 93999 95000 - 96020	Cardiography, Catheterization, & Vascular Studies Allergy / Neuromuscular Procedures	~~$70~~ $72.24**

*(**This figure has been corrected on this copy only. It published incorrectly in the Bulletin but will be corrected once the proposed rule has been adopted and publishes as a pending rule.)* ~~(1-2-08)~~( )

c. The Conversion Factor for the Anesthesiology CPT Codes shall be multiplied by the Anesthesia Base Units assigned to that CPT Code by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services as of December 31 of the previous calendar year, plus the allowable time units reported

for the procedure. Time units are computed by dividing reported time by fifteen (15) minutes. Time units will not be used for CPT Code 01996. (4-2-08)

d. Adjustment of Conversion Factors. The conversion factors set out in this rule shall be adjusted each fiscal year (FY), starting with FY 2009, as determined by the director of the Department of Health and Welfare using the methodology set forth in section 56-136, Idaho Code, pursuant to Section 72-803, Idaho Code. (4-2-08)

e. Services Without CPT Code, RVU or Conversion Factor. The acceptable charge for medical services that do not have a current CPT code, a currently assigned RVU, or a conversion factor will be the reasonable charge for that service, based upon the usual and customary charge and other relevant evidence, as determined by the Commission. Where a service with a CPT Code, RVU, and conversion factor is, nonetheless, claimed to be exceptional or unusual, the Commission may, notwithstanding the conversion factor for that service set out in Subsection 031.02.b., determine the acceptable charge for that service, based on all relevant evidence in accordance with the procedures set out in Subsection 032.10. (4-2-08)

f. Coding. The Commission will generally follow the coding guidelines published by the Centers for Medicare and Medicaid Services and by the American Medical Association, including the use of modifiers. The procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. Modifiers that affect payment will be reimbursed as follows: ~~(3-12-07)~~( )

i. Modifier 50: Additional fifty percent (50%) for bilateral procedure. (3-12-07)

ii. Modifier 51: Fifty percent (50%) of secondary procedure. This modifier will be applied to each medical or surgical procedure rendered during the same session as the primary procedure. (3-12-07)

iii. Modifier 80: Twenty-five percent (25%) of coded procedure. (3-12-07)

iv. Modifier 81: Fifteen percent (15%) of coded procedure. This modifier applies to MD and non-MD assistants. (3-12-07)

g. Adoption of Standard for Hospitals. The Commission hereby adopts the following standards for determining the acceptable charge for hospital services. ( )

i. Critical Access and Rehabilitation Hospitals. The standard for determining the acceptable charge for inpatient and outpatient services provided by a critical access or rehabilitation hospital is ninety percent (90%) of the reasonable charge. The acceptable charge for implantable hardware shall be the actual cost plus fifty percent (50%). ( )

ii. Hospital Inpatient Services. The standard for determining the acceptable charge for inpatient services provided by hospitals, other than critical access and rehabilitation hospitals, is calculated by multiplying the base rate by the current MS-DRG weight for that service. The base rate is eleven thousand two hundred dollars ($11,200). Inpatient services that do not have a DRG code or relative weight shall be paid at eighty-five percent (85%) of the reasonable charge. ( )

iii. Hospital Outpatient and Ambulatory Surgical Center (ASC) Services. The standard for determining the acceptable charge for outpatient services provided by hospitals (other than critical access and rehabilitation hospitals) and for services provided by ambulatory surgical centers is calculated by multiplying the base rate by the current APC weight. The base rate for a hospital is one hundred forty-three dollars ($143). The base rate for an ASC is ninety-three dollars ($93). ( )

(1) If there is no weight listed for APC status codes A, B, C, D, E, F, G, H, K, L, M, Q, S, T, V, X, or Y, then reimbursement shall be seventy-five percent (75%) of the reasonable charge. ( )

(2) Status code N items (other than implantable hardware) or items with no CPT or Healthcare Common Procedure Coding System (HCPCS) code shall receive no payment. ( )

(3) Two (2) or more medical procedures with a status code T on the same claim shall be reimbursed

with the highest weighted code paid at one hundred percent (100%) of the APC calculated amount and all other status code T items paid at fifty percent (50%). ( )

(4) Status code Q items will not be discounted. ( )

iv. Hospitals Outside of Idaho. Reimbursement for services provided by hospitals outside the state of Idaho may be based upon the agreement of the parties. If there is no agreement, services shall be paid in accordance with the workers' compensation fee schedule in effect in the state in which services are rendered. If there is no fee schedule in effect in such state, or if the fee schedule in that state does not allow reimbursement for the services rendered, reimbursement shall be paid in accordance with these rules. ( )

v. Additional Hospital Payments. When the charge for a medical service provided by a hospital (other than a critical access or rehabilitation hospital) meets the following standards, additional payment shall be made for that service as indicated. ( )

(1) Inpatient Threshold Exceeded. When the charge for a hospital inpatient MS-DRG coded service exceeds thirty thousand dollars ($30,000) plus the payment calculated under the provisions of Subparagraph 031.02.g.ii. of this rule, the total payment for that service shall be the sum of the MS-DRG payment and the amount charged above that threshold multiplied by seventy-five percent (75%). ( )

(2) Outpatient Threshold Exceeded. When the charge for a hospital or ASC outpatient APC coded service exceeds one thousand dollars ($1,000) plus the payment calculated under the provisions of Subparagraph 031.02.g.iii. of this rule, the total payment for that service shall be the sum of the APC payment and the amount charged for that service above that threshold multiplied by seventy-five percent (75%). ( )

(3) Inpatient Implantable Hardware. Hospitals may seek additional reimbursement beyond the MS-DRG payment for invoiced implantable hardware. Additional reimbursement shall be the invoice cost plus ten percent (10%). Handling and freight charges shall be included in invoice cost. When a hospital seeks additional reimbursement pursuant to this rule, that additional implantable charge shall be excluded from the calculation for an additional inpatient payment under Subparagraph 031.02.g.v.(1) of this rule. ( )

(4) Outpatient Implantable Hardware. Hospitals and ASCs may seek additional reimbursement beyond the APC payment for invoiced implantable hardware. Additional reimbursement shall be the invoice cost plus ten percent (10%). Handling and freight charges shall be included in invoice cost. When a hospital seeks additional reimbursement pursuant to this rule, that additional implantable charge shall be excluded from the calculation for an additional outpatient payment under Subparagraph 031.02.g.v.(2) of this rule. ( )

h. Paragraph 031.02.e. of this rule shall not apply to hospitals or ASCs. The Commission shall determine the acceptable charge for hospital and ASC services that are disputed based on all relevant evidence in accordance with the procedures set out in Subsection 032.10. ( )

i. Adjustment of Hospital and ASC Base Rates. The Commission may periodically adjust the base rates set out in Subparagraphs 031.02.g.ii. and 031.02.g.iii. of this rule to reflect changes in inflation or market conditions. ( )

032. BILLING AND PAYMENT REQUIREMENTS FOR MEDICAL SERVICES AND PROCEDURES PRELIMINARY TO DISPUTE RESOLUTION.

01. Authority and Definitions. Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Industrial Commission hereby promulgates this rule augmenting IDAPA 17.02.08.031. The definitions set forth in IDAPA 17.02.08.031 are incorporated by reference as if fully set forth herein. (3-12-07)

02. Time Periods. None of the periods herein shall begin to run before the Notice of Injury/Claim for Benefits has been filed with the Employer as required by law. (1-1-93)

03. Provider to Furnish Information. A Provider, when submitting a bill to a Payor, shall inform the Payor of the nature and extent of medical services furnished and for which the bill is submitted. This information

shall include, but is not limited to, the patient's name, the employer's name, the date the medical service was provided, the diagnosis, if any, and the amount of the charge or charges. Failure to submit a bill complying with Subsection 032.03 to the Payor within one hundred twenty (120) days of the date of service will result in the ineligibility of the Provider to utilize the dispute resolution procedures of the Commission set out in Subsection 032.10 for that service. (3-12-07)

a. CPT and ICD Coding. A Provider's bill shall, whenever possible, describe the Medical Service provided, using the American Medical Association's appropriate Current Procedural Terminology (CPT) coding, including modifiers, for the year in which the service was performed and using current International Classification of Diseases (ICD) diagnostic coding, as well. (7-1-95)

b. Contact Person. The bill shall also contain the name, address and telephone number of the individual the Payor may contact in the event the Payor seeks additional information regarding the Provider's bill. (1-1-93)

c. Report to Accompany Bill. If requested by the Payor, the bill shall be accompanied by a written report as defined by IDAPA 17.02.04.322.01.f. Where a bill is not accompanied by such Report, the periods expressed in Subsections 032.04 and 032.06, below, shall not begin to run until the Payor receives the Report. (3-12-07)

04. Prompt Payment. Unless the Payor denies liability for the claim or, pursuant to Subsection 032.06, sends a Preliminary Objection Request for Clarification, or both, as to any charge, the Payor shall pay the charge within thirty (30) calendar days of receipt of the bill. (3-12-07)

05. Partial Payment. If the Payor acknowledges liability for the claim and, pursuant to Subsection 032.06 below, sends a Preliminary Objection, a Request for Clarification, or both, as to only part of a Provider's bill, the Payor must pay the charge or charges, or portion thereof, as to which no Preliminary Objection and/or Request for Clarification has been made, within thirty (30) calendar days of receipt of the bill. (3-12-07)

06. Preliminary Objections and Requests for Clarification. (1-1-93)

a. Preliminary Objection. Whenever a Payor objects to all or any part of a Provider's bill on the ground that such bill contains a charge or charges that do not comport with the applicable administrative rule, the Payor shall send a written Preliminary Objection to the Provider within thirty (30) calendar days of the Payor's receipt of the bill explaining the basis for each of the Payor's objections. (1-1-93)

b. Request for Clarification. Where the Payor requires additional information, the Payor shall send a written Request for Clarification to the Provider within thirty (30) calendar days of the Payor's receipt of the bill, and shall specifically describe the information sought. (1-1-93)

c. Provider Contact. Each Preliminary Objection and Request for Clarification shall contain the name, address and phone number of the individual located within the state of Idaho that the Provider may contact regarding the Preliminary Objection or Request for Clarification. (3-12-07)

d. Failure of Payor to Object or Request or Provide Contact. Where a Payor does not send a Preliminary Objection to a charge set forth in a bill and/or a Request for Clarification within thirty (30) calendar days of receipt of the bill, or provide an in-state contact in accord with Subsection 032.06.c., it shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. (3-12-07)

07. Provider Reply to Preliminary Objection and/or Request for Clarification. (1-1-93)

a. Where a Payor has timely sent a Preliminary Objection, Request for Clarification, or both, the Provider shall send to the Payor a written Reply, if any it has, within thirty (30) calendar days of the Provider's receipt of each Preliminary Objection and/or Request for Clarification. (1-1-93)

b. Failure of Provider to Reply to Preliminary Objection. If a Provider fails to timely reply to a Preliminary Objection, the Provider shall be deemed to have acquiesced in the Payor's objection. (1-1-93)

c. Failure of Provider to Reply to Request for Clarification. If a Provider fails to timely reply to a Request for Clarification, the period in which the Payor shall pay or issue a Final Objection shall not begin to run until such clarification is received. (1-1-93)

08. Payor Shall Pay or Issue Final Objection. The Payor shall pay the Provider's bill in whole or in part and/or shall send to the Provider a written Final Objection, if any it has, to all or part of the bill within thirty (30) calendar days of the Payor's receipt of the Reply. (1-1-93)

09. Failure of Payor to Finally Object. Where the Payor does not timely send a Final Objection to any charge or portion thereof to which it continues to have an objection, it shall be precluded from further objecting to such charge as unacceptable. (1-1-93)

10. Dispute Resolution Process. If, after completing the applicable steps set forth above, a Payor and Provider are unable to agree on the ~~*appropriate*~~ charge for any Medical Service, a Provider which has complied with the applicable requirements of this rule may ~~*move the Commission*~~ file a request to resolve the dispute as provided in the Judicial Rule Re: Disputes Between Providers and Payors as Referenced in Sections 031 and 032 of this rule. If Provider's motion disputing CPT or MS-DRG coded items prevails, Payor shall pay the amount found by the Commission to be owed, plus an additional thirty percent (30%) of that amount to compensate Provider for costs and expenses associated with using the dispute resolution process. ~~*For motions filed by a hospital or ambulatory surgical center, under section 031.02.a.v., or by a provider under 031.02.e, the additional thirty percent (30%) shall be due only if the Payor does not pay the amount found due within thirty (30) days of the administrative order.*~~

~~*(3-12-07)*~~( )